

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09155

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and <u>Jessups rural</u> ) c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colie Trailer Camp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups rural</u> d. STREET ADDRESS <u>Box 301</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MATTIE CRADDOCK</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Aug. 15, 1959</u> 19															
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 28, 1895</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>11. IF UNDER 24 HRS.</b> Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>							
<b>13. FATHER'S NAME</b> <u>Arthur Soy</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sophia ?</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>?</u>				<b>17. INFORMANT</b> <u>Troy Craddock, Laurel, Md</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>1 yr</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Hour e. m. p. m. 19				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>																			
<b>ACTUAL SIGNATURE</b> <u>George E. Burgtorf</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>Aug. 15, 1959</u>							
<b>EXAMINER'S NAME (Type)</b> <u>George E. Burgtorf</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>										<b>22b. DATE THEREOF</b> <u>8-19-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Belhaven</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Belhaven, N.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F.C. Higinbotham, Ellicott City, Md</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>AUG 18 '59</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09156

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HOWARD</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 LAUREL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>109 Whiskey Bottom Road</u>				d. STREET ADDRESS <u>109 WHISKEY BOTTOM RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CARROLL JACOB EDLER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>8 9 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY  		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?  			
13. FATHER'S NAME <u>Jacob Edler</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Arnold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>World War I</u>		17. INFORMANT <u>FRANKLIN J. REEDER</u>		Address <u>SCAGGSVILLE MD.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> <u>783.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>NONE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald E. Fisher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DONALD E. FISHER M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fisher &amp; Sons</u>				ADDRESS <u>Baltimore - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
NEWLAND STATE DEPARTMENT OF HEALTH—BIRMINGHAM

9186

## CERTIFICATE OF DEATH

09157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>268 Main St.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>268 Main St.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>268 Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MELISSA GLOVER</b>				4. DATE OF DEATH <b>Aug. 16, 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-14-1895</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <b>Walter Quarterbaum</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>James Glover, Highland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>Arteriosclerotic Cardio-Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>—</b> <b>4 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Oct 10</b> 19 <b>53</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 15</b> , 19 <b>59</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William F. Gassaway</b>				ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b>		DATE SIGNED <b>Aug. 16-59</b>	
PHYSICIAN'S NAME (Type) <b>William F. Gassaway</b>				ELICOTT CITY, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>		22d. LOCATION (City, town, or county) (State) <b>St. Matthews, S.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

2151

STATE OF MARYLAND, DEPARTMENT OF HEALTH - BALTIMORE

Name: *James Oliver, Richard M.* Sex: *Male* Race: *White* Date of Birth: *Jan. 16, 1909*

Place of Birth: *North Carolina* Date of Death: *Jan. 16, 1959*

Time of Death: *10:30 AM* Cause of Death: *Heart failure*

Place of Death: *Home* Physician: *Dr. J. H. Jones*

Signature of Physician: *J. H. Jones* Signature of Registrar: *J. H. Jones*

Signature of Coroner: *J. H. Jones* Signature of Medical Examiner: *J. H. Jones*

Signature of Burial Director: *J. H. Jones* Signature of Undertaker: *J. H. Jones*

Signature of Minister: *J. H. Jones* Signature of Pastor: *J. H. Jones*

Signature of Rector: *J. H. Jones* Signature of Chaplain: *J. H. Jones*

Signature of Minister of Music: *J. H. Jones* Signature of Organist: *J. H. Jones*

Signature of Choir Director: *J. H. Jones* Signature of Soloist: *J. H. Jones*

Signature of Cantor: *J. H. Jones* Signature of Organist: *J. H. Jones*

Signature of Organist: *J. H. Jones* Signature of Organist: *J. H. Jones*

Signature of Organist: *J. H. Jones* Signature of Organist: *J. H. Jones*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9187

## CERTIFICATE OF DEATH

09158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Schaefers Conval. Home</b>		d. STREET ADDRESS <b>6805 Duluth Avenue #22</b>	
3. NAME OF DECEASED (Type or print) <b>CALVIN TURNER GRIER, SR.</b>		4. DATE OF DEATH <b>August 10 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick A. Grier</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Fehrenbach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-3627</b>	
17. INFORMANT <b>Mr. Calvin Grier-Rt. 1, Montgomery Rd.-Ellicott</b>		Address <b>City</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>153.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMATOSIS</b> DUE TO (c) <b>CANCER OF BOWEL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos</b> <b>3 Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-10</b> , 19 <b>59</b> , to <b>8-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-10</b> , 19 <b>59</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. V. Thorpe</b>		ADDRESS (Street, city or town, state) <b>COLUMBIA RD</b>	
PHYSICIAN'S NAME (Type) <b>PETER V. THORPE MD</b>		DATE SIGNED <b>8-11-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. ...</b>		ADDRESS <b>Baltimore - 17, Md.</b>	
24a. REC'D BY REGISTRAR <b>...</b>		24b. REGISTRAR'S SIGNATURE <b>...</b>	

CERTIFICATE OF DEATH

112

WILLIAM J. BROWN

NAME	WILLIAM J. BROWN
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	1880
PLACE OF BIRTH	New York City
DATE OF DEATH	1925
PLACE OF DEATH	New York City
Cause of Death	Heart Disease
Signature of Physician	[Signature]
Signature of Registrar	[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09159

9188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smoot (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smoot (Rural)</u>	
c. LENGTH OF STAY in 1b <u>88 yrs</u>		d. STREET ADDRESS <u>Seagoville Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seagoville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Daniel Harding</u>		4. DATE OF DEATH <u>August 11 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Basill W. Harding</u>		14. MOTHER'S MAIDEN NAME <u>Martha Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary Harding, Laurel, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>1919</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Skin</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20, 1959</u> , to <u>Aug 11, 1959</u> , that I last saw the deceased alive on <u>Aug 11, 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCeney</u> M.D.		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY</u>		ADDRESS (Street, city or town, state) <u>402 MAIN ST. LAUREL, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Seagoville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McWitt &amp; Canadian, Laurel Md</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>AUG 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

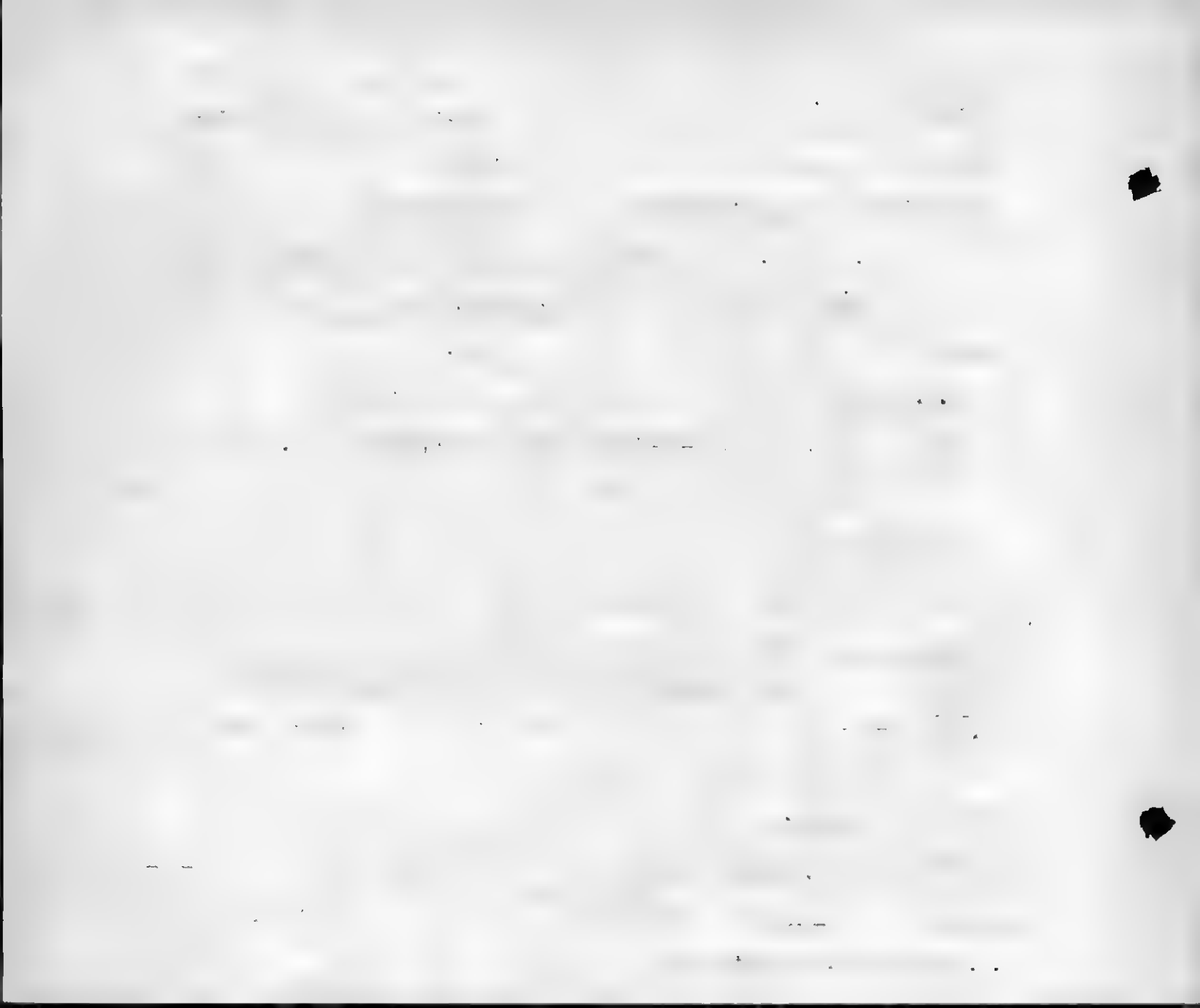
Reg. Dist. No.

09160

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Arundel Gravel Pit Gorman Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Howard</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b> d. STREET ADDRESS <b>Box 151 A Rt 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>A. D. HUNLEY</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>August 28 19 59</b>															
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 19, 1924</b>		<b>9. AGE</b> (In years last birthday) <b>35</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Tenn.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Tenn.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <b>A.S. Hunley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Maudie Bailey</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW 2</b>				<b>16. SOCIAL SECURITY NO.</b> <b>414-20-5715</b>				<b>17. INFORMANT</b> <b>James Hunley, Laurel Rt. 1 Md</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a) stating the underlying cause lost. (b) _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Dual rear wheels of dump truck passed over head</b>															
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>4:30 P. M. 8-28-59 19</b>				<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Gravel pit</b>		<b>20f. (City or town)</b> <b>Savage</b> <b>Howard</b> <b>Md</b>		<b>(County)</b> <b>Howard</b> <b>(State)</b>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>																			
<b>ACTUAL SIGNATURE</b> <i>George E. Burgdorf</i>				<b>EXAMINER'S NAME (Type)</b> <b>George E. Burgdorf M D</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>8-28-59</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>9-1-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Meadowridge</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Elkridge, Md</b> <b>(State)</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F.C. Higinbotham, Ellicott City, Md</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 31 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hines</i>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Frederick Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Old Frederick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>STANLEY GLENN KEFAUVER</b>		4. DATE OF DEATH Month Day Year <b>Aug. 24, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6, 1895</b>
9. AGE (In years lost birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boarding Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Middletown, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Middletown, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Kefauver</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-1024</b>	
INFORMANT <b>Emerson Kefauver, Ellicott City, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Cardio-Respiratory failure</b> DUE TO (b) <b>Myocardial degeneration &amp; hypertrophy</b> DUE TO (c) <b>Due to Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Fay</b> , 1950, to <b>24 Aug, 1959</b> , that I last saw the deceased alive on <b>24 Aug, 1959</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William F. Bryson M.D. 4605 Elmwood Ave Bath, 29 MD</b>			
ACTUAL SIGNATURE <b>William F. Bryson</b>		PHYSICIAN'S NAME (Type) <b>William F. Bryson</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reform</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>AUG 26 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>41 Fells Avenue</b>					d. STREET ADDRESS <b>41 Fells Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>S</b> Last <b>Myers</b>					4. DATE OF DEATH Month <b>8</b> Day <b>20</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-28-1954</b>		9. AGE (In years last birthday) <b>4</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Charles Myers</b>					14. MOTHER'S MAIDEN NAME <b>Shirley Bacon</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Shirley Bacon, Ellicott City, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Colitis and generalized dehydration</b> <b>571.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED <b>8/21/59</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-24-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>			22d. LOCATION (City, town, or county) (State) <b>Catonsville, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>					24a. REC'D BY REGISTRAR <b>Aug 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>		

MISSOURI STATE DEPARTMENT OF HEALTH - COLUMBIA, MO.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Witnesses		Physician		Nurse	
Funeral Home		Burial Place		Date of Burial	
Remarks		Disposition of Body		Disposition of Organs	
Disposition of Records		Disposition of Certificate		Disposition of Certificate	

MISSOURI STATE DEPARTMENT OF HEALTH - COLUMBIA, MO.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Handwritten Signature]*